

Provider/Agency: _____

Review Period: _____ thru _____

Date of Review: _____

Client Name:	Avatar #
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Item #	Charting Standards	YES	NO	N/A
1.	<i>Network Provider Initial Authorization in file?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<i>Request for Reauthorization/Treatment Plan Report (CARE—009) in file?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<i>Assessment (Care 005) dated within 3 years?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a.	Presenting Problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Developmental history, including pre-natal and perinatal events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Relevant family history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Social supports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Substance abuse history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Mental health services history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Medical history, including allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Medication history, including medication allergies, adverse reactions to medications, or lack of known allergies/sensitivities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Mental status?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Assessment of risk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Client strengths?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Signature and Licensure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	DSM IV-TR 5 axis diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n.	If the assessment was completed by a registered intern is there a licensed supervisor co-signature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o.	Changes/corrections have been initialed by worker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Auditor Comments:

Provider Corrections/Copies of the completed corrections or missing notes have been attached for review (REQUIRED):

Provider/Agency: _____

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Item #	Charting Standards	Yes	No	N/A
4.	Treatment Plan in file for entire review period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a.	Specific, observable, and/or quantifiable goals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Proposed type(s) of interventions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Proposed duration of interventions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Focus of intervention consistent with client plan goals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Plan consistent with diagnosis(es)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Signed by appropriate provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Signed by client or parent/guardian?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Other documents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a.	Consent for treatment of minor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Progress Notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a.	Are the CARE041 and CARE041g Progress Notes being used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Actual date service was provided?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Location of service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Time units (in minutes) recorded in progress notes as reflected in billing statements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Type of service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Name of client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	A clear but brief synopsis of services and specific intervention (i.e. problem Solving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Signature of service provider and their degree, license, or job title?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Changes/corrections have been initialed by worker? (no sticky notes or white-out used)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	For Group services, the group billing formula has been completed correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Item #	Charting Standards	Yes	No	N/A
7.	POSTED MATERIALS IN ENGLISH AND SPANISH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a.	Guide to Medi-Cal MH Poster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Grievance Appeal Forms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Envelopes on display	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Grievance/Appeal Poster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Patients' Rights Poster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Handicapped Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Auditor Comments:

Provider Corrections/Copies of the completed corrections or missing notes have been attached for review:

Reviewer Signature:	Date:
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- ☐ Michelle Johnson (916) 784-6427
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